MEDICARE SUPPLEMENT INSURANCE PREMIUM COMPARISON GUIDE

State of Nevada

Department of Business & Industry

Division of Insurance

2011

Brett J. Barratt, Commissioner of Insurance

Brian Sandoval, Governor **Terry Johnson, Director**

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To be used with the <u>Guide to Health Insurance for People with Medicare</u> as developed by the National Association of Insurance Commissioners (NAIC) and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services (CMS).

LETTER FROM THE COMMISSIONER

Dear Fellow Nevadan:

The decisions whether or not to purchase Medicare supplement insurance, and which kind of insurance to buy, are important ones. However, shopping for this insurance requires time and effort and can be confusing. That is why we are pleased to provide you with a copy of Nevada's "Medicare Supplement Insurance Premium Comparison Guide." This Guide provides valuable information that will assist you in comparing many of the Medicare supplement policies and Medicare Advantage plans currently being offered in Nevada.

You may wish to seek the advice of a licensed agent, broker, producer or consultant to assist you in selecting a Medicare supplement policy or Medicare Advantage plan. Another source of information is the Nevada Department of Health and Human Services, Division for Aging Services, which administers the Nevada State Health Insurance Assistance Program (SHIP). The program director and volunteer counselors are available to provide you with individual counseling concerning your questions on Medicare or Medicare supplement products.

Your insurance concerns are very important to us at the Division of Insurance. We are here to assist you with any insurance questions or problems you may have.

Our offices in Northern Nevada are located in Carson City. For information, please call our consumer services section at (775) 687-0700. In Southern Nevada, our offices are located in Las Vegas, and you may reach a consumer services officer at (702) 486-4009. The toll-free number for use in Nevada is 1-888-872-3234. The Nevada SHIP advisers may be reached at (702) 486-3478 in Las Vegas or toll free in Nevada at 1-800-307-4444.

Sincerely,

BRETT J. BARRATT
Commissioner of Insurance

INTRODUCTION

Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill gaps in original Medicare plan coverage. Medicare does not pay for every medical expense which is why many people purchase supplemental insurance to fill the "gap" left by Medicare. Insurance companies may offer 10 standard and one high-deductible Medicare supplement policies, Plans A through N.

According to the Kaiser Family Foundation, 354,488 Nevadans were eligible to receive benefits through the federal Medicare program as of November 30, 2010. Of these, 108,639 individuals (30.6%) received their benefits through Medicare Advantage Plans. The remaining 245,849 Medicare recipients (69.4%) received their benefits through traditional fee-for-service Medicare.

The Nevada Division of Insurance ("Division") surveyed the companies writing Medicare supplement coverage in Nevada to collect information on the premiums for the policies. Participation is voluntary and the results of that survey are summarized in the section of the Guide titled "Premium Comparisons." The comparisons shown in the Guide will give you a start in shopping for Medicare supplement coverage by offering a ready means for comparing premium costs on policies.

Although Medicare supplement insurance is sold mainly to senior citizens, a few insurance companies offer coverage for disabled persons under the age of 65 who qualify for Medicare benefits. These companies are marked with an "*" next to their name in the tables on pages 25 – 28.

This Comparison Guide is designed to help you decide on health insurance coverage to supplement your Medicare. It does not explain Medicare itself. If you already are on Medicare, you may want to read "Medicare and You," a guide published by the Centers for Medicare and Medicaid Services. "Medicare and You" summarizes Medicare benefits, rights and obligations, and provides answers to the most frequently asked questions about Medicare. This information is available on the Medicare Web site: http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

If you are not yet on Medicare, or if you have misplaced your copy of the handbook, you may obtain another copy and other information from the Division, the Nevada State Health Insurance Assistance Program (SHIP) or your local Social Security office. Please see pages 43 and 44 of this Guide for contact information.

DEFINITIONS

The following terms are commonly used in Medicare supplement and long-term care insurance policies. Definitions differ from policy to policy, so it is important to understand the definition used in a specific insurance policy before you purchase it.

Allowed, approved, or eligible charges: The basis by which Medicare pays for health care costs. The approved charge paid by Medicare may be only 60 to 80% of the actual charge.

Assignment: In the original Medicare plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit (.

Advance directives: Legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself.

Attained Age: Current age of an insured person, computed by adding the period elapsed since issue of insurance policy to his or her age when the policy was issued.

Benefit: A benefit is a health care service or supply that is paid for in part or in full by Medicare.

Benefit period: A specified number of days, months or years for which benefits will be payable during any one confinement or spell of illness, or for successive confinements for the same condition.

Body mass index (BMI): A measure of body fat based on height and weight that applies to both adult men and women.

Chronic: A chronic condition is one lasting three months or more.

Co-insurance or co-payment: The portion of a charge for a covered medical service that you must pay out of your own pocket. For example, Part B of Medicare generally has a required co-payment of 20% of the Medicare-approved amount for a covered service.

Custodial care: The level of care required to assist an individual in the activities of daily living. This care helps meet personal needs and can be provided by persons without professional licenses or extensive training.

Deductible: The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.

Effective date: The date on which insurance coverage goes into effect. It is not always the same as the date the application is completed.

Enrollment period: A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Excess charges: The portion of the Medicare provider's charges which exceed Medicare's approved payment amount.

Exclusion or limitation: A specific service, expense, condition or situation not covered by an insurance plan.

Fee for service: In health care, a payment mechanism in which a provider is paid for each individual service rendered to a patient.

Guaranteed issue: A policy of insurance that will be issued regardless of health condition.

Guaranteed renewable: The policy must be renewed by the company for as long as premiums are paid in a timely manner.

Health maintenance organization (HMO): A type of Medicare Advantage plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists or hospitals on the plan's list, except in an emergency. Your costs may be lower than in the original Medicare plan.

Health Savings Account (HSA): Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families; and are open to anyone who enrolls in a high-deductible health insurance plan.

Home health care: A wide variety of skilled nursing care and supportive services for individuals who do not need institutional care. The services are available through intermittent visits and may include nursing care, physical therapy, speech, and hearing therapy, occupational therapy, social services, and other support services.

Intermediate care: Less intensive care than skilled nursing care. Its definition may vary from policy to policy. It usually includes assistance with activities of daily living with the availability of any on-duty registered nurse.

Issue Age: These policies are priced at your age when you initially purchase the policy.

Lapse: Termination of a policy due to failure by the policyholder to pay the required premium within the time specified in the policy.

Limiting charge: The highest dollar amount you can be charged for a covered service by doctors and other health care providers who do not accept assignment. The limit is 15%

over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. (See Approved Amount; Assignment.)

Long-term care: A wide range of routine and complex services designed to provide maintenance, preventive, rehabilitative and supportive services to those individuals who have conditions that impair their ability to function independently.

Managed care: A system of health care where the goal is a system that delivers quality, cost-effective health care through monitoring and recommending utilization and cost of services.

Medically necessary: Reasonable and necessary services for diagnosis or treatment as generally accepted by health care professionals that are clinically appropriate with regard to type, frequency, extent, location and duration; not primarily provided for the convenience of the patient, physician or other provider of healthcare; required to improve a specific health condition of an insured or to preserve his existing state of health; and the most clinically appropriate level of health care that may be safely provided to the insured.

Medicare Advantage plan: A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and are not paid for under Original Medicare.

Medicare managed care plans: These are health care choices (such as HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, such as preventive care not covered by Medicare. Your costs may be lower than in the original Medicare plan.

Network: A list of primary care doctors, specialists and hospitals that members of a managed care organization can go to. Doctors, hospitals and other health care providers who have contracted with the health insurer or a third-party administrator provide health care at a reduced rate to members within the network.

Open enrollment: A period when new beneficiaries may elect to enroll in a policy of insurance regardless of health. For a Medicare supplement policy this is the six-month period, when an individual is age 65 or older and enrolled in Part B of Medicare.

Out-of-pocket costs: Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Point of service (POS): A managed care plan that allows you to use doctors and hospitals outside the plan for an additional cost. (See Medicare managed care plan.)

Pre-existing condition: A physical condition for which medical advice was given or treatment was recommended or received from a doctor within a specified period before the effective date of coverage.

Preferred provider organization (PPO): Health service organization plan with a network of physicians and suppliers who contract to provide services to a health insurance plan on a discounted fee-for-service basis.

Skilled nursing care: Medically necessary care that can only be provided by, or under the supervision of, skilled, licensed, medical professionals such as registered nurses or professional therapists. All skilled services require a physician's order. Medicare's definition is often different from the definitions used in many Medicare supplement and long-term care insurance policies.

State Health Insurance Assistance Program ("SHIP"): SHIP refers to a group of federal and state funded programs. These programs work together to provide assistance with public and private health insurance issues and options to Medicare beneficiaries or those soon to

be Medicare beneficiaries, their families and caregivers. SHIP has a centralized component of statewide assistance and a local component of county- and tribal-based benefit counselors.

TRICARE: TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide.

Underwriting: The process by which an insurer determines whether or not, and on what basis, it will accept an application for insurance.

Usual and customary or reasonable charges: The fee most commonly charged by physicians or providers for a particular service, treatment or supply. This fee may vary from area to area throughout the state.

10 MEDICARE SUPPLEMENT PLANS: A THROUGH N

You can choose from 10 different Medicare supplement policies. No matter what company you buy from, the 10 plans are identical from company to company. Plans E, H, I and J are no longer sold to new Medicare eligible enrollees. An insurer may not offer all plans. The plans are described on the chart on page 24, which shows the benefits in each plan. These same charts will be included in every company's sales material. In addition to the 10 plans, insurers may offer one high-deductible version of Plan F. This plan includes the same coverage as Plan F, except the policyholder is responsible for the first $2,000 of medical expenses each year (adjusted annually). The premium for this high-deductible plan is significantly less than the premium for regular plans.

Plans K and L cover 50% and 75%, respectively, of the co-insurance for basic benefits, skilled nursing and the Part A deductible. Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does **not** include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You are responsible for paying excess charges unless you have

Medicare supplement policies F, G or high-deductible Plan F, which cover 100% of the Medicare Part B excess charges.

Implemented Changes

Effective June 1, 2010, CMS revised the Medicare supplement plans by creating new Medicare supplement plans and revising existing plans. Previously, there were 12 different standardized Medicare supplement plans in force, plus High-Deductible Plan F and High-Deductible Plan J. After the modernization revisions were implemented, there are 10 plans available (Plans A-D, Plan F, Plan G and Plans K-N), plus High-Deductible Plan F. The plans are described on the chart on page 24, which shows the benefits in each plan.

As a result of the revisions, Plan H, Plan I, Plan J and High-Deductible Plan J have been eliminated. Prescription drug benefits were removed from these plans by the Medicare Modernization Act of 2003. Now that Preventive Care and At-Home Recovery benefits are eliminated, these plans also became unnecessary and duplicative of other plans. Plan E also was also eliminated. Once other benefit changes were made (in particular the replacement of the 80% Part B Excess Charge benefit with a 100% Part B Excess Charge benefit) this plan became unnecessary and duplicative of another plan. The preventive care and at-home recovery benefits were eliminated because they are underutilized and outdated benefits that will either be available under Medicare Part B, are not subject to Medicare's deductible and co-payment requirements, or they no longer provide a significant benefit.

A new Plan M and new Plan N were created. These plans are designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium. Plan M includes 50% coverage of the Part A deductible and no coverage of the Part B deductible. Plan N includes 100% coverage of the Part A deductible but no coverage for the Part B deductible.

In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new co-pay structure. The co-pay is up to $20 for office visits and up to $50 for emergency room visits. The Hospice benefit has also been added as a Basic (core) benefit, which will ensure that hospice coverage is available to all beneficiaries. (Note that Plans K and L already include

hospice coverage.) The new hospice benefit covers cost sharing for all Part A eligible hospice and respite care expenses.

Medicare Parts A and B

The amount of your coverage is also dependent on whether you have coverage under Medicare Part A, Medicare Part B, or both. Medicare Part A typically pays for your inpatient hospital expenses, and Medicare Part B typically covers your outpatient health care expenses including doctor fees. Remember, a benefit is a health care service or supply that is paid for in part or in full by Medicare.

Medicare Advantage plans must cover at least the same benefits covered under Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, such as coverage for prescription drugs or extra days in the hospital. You should contact your Medicare Advantage plan administrator for specific coverage information for the plan in which you are enrolled. **Note: Not all doctors accept Medicare Advantage plans, so be sure to check first!**

Medicare Part D

There are two types of Medicare plans that may help lower prescription drug costs and help to protect against higher costs in the future. There is prescription drug coverage that is a part of Medicare Advantage plans and other Medicare health plans. Your Medicare health care is provided through these plans. There is also Medicare prescription drug coverage, called Medicare Part D, that provides additional coverage to the original Medicare plan, and some Medicare cost plans and Medicare private fee-for-service plans. These Medicare Part D plans are offered by insurance companies and other private companies approved by Medicare.

Both types of plans cover different prescriptions, so you will want to review each carefully. You choose the drug plan and pay a monthly premium. If you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later.

Like other insurance, Medicare prescription drug coverage has a yearly deductible (up to $310), and requires monthly premium payments. If you have limited income and resources, you may

get extra help from CMS to cover prescription drugs for little or no cost. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, deductible, and copayments. The amount of extra help you get is based on your income and resources. You have to join a Medicare drug plan to get extra help paying your drug costs, and the amount of the monthly premium is not affected by your health status or how many prescriptions you need.

Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent a certain amount of money for covered drugs ($2,840 in total), you are responsible for all out-of-pocket costs for your drugs up to a limit of $4,550. Your yearly deductible, your co-insurance or co-payments, and what you pay in the coverage gap all count toward this out-of-pocket limit, but the limit doesn't include the drug plan's premium. After you reach this out-of-pocket limit, Medicare pays 95% of the costs for the rest of the year.
All drug plans must provide coverage at least as good as the standard coverage set by Medicare. However, some plans might offer more coverage and cover additional drugs for a higher monthly premium. If your employer or union offers prescription drug coverage, you may not need a Medicare drug plan.

Joining a Medicare Prescription Drug Plan

You can join a Medicare prescription drug plan during your initial enrollment period, which is three months before the month you turn age 65 until three months after the month you turn age 65. If you get Medicare due to disability, you can join from three months before to three months after your 25th month of disability.

If you did not join when you were first eligible, you can join during the late enrollment period, which is between November 15 and December 31 of each year, with a 1% penalty for every month you were eligible to join, but did not. If you apply and qualify for extra financial help from CMS, you may enroll one time during the calendar year (without having to wait for the annual open enrollment period). **Note: In the fall of 2011, the Annual Enrollment Period dates will change to give you more time if you want to choose and join a Medicare health or prescription drug plan. You will be able to switch your coverage between October 15, 2011—December 7, 2011. If you make a change during this period, your new coverage will**

begin January 1, 2012. For tips on understanding Medicare enrollment periods, please see http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf.

Prior to the Part D enrollment period, Medicare supplement insurers are required to provide a written notice to their subscribers who have drug coverage explaining what their options will be. For more information visit the CMS Web site www.cms.hhs.gov or call (410) 786-3000 or toll free: (877) 267-2323.

TIP: If you change your insurance plan, your spouse or dependents may not be able to get healthcare and prescription drug benefits.

"Welcome to Medicare" physical exam

Medicare covers a one-time preventive physical exam **within the first 12 months** that you have Part B. The exam will include a thorough review of your health, education, and counseling about the preventive services you need (such as certain screenings and shots), and referrals for other care. The Welcome to Medicare physical exam is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy. You just pay 20% of the Medicare-approved amount, and no Part B deductible.

During the exam, your doctor will record your medical history and check your blood pressure, vision, weight and height to measure your body mass index. Your doctor will check to make sure that you are up-to-date with preventive screenings and services, such as cancer screening and shots. Your doctor also will give you advice on preventing disease, improving your health or staying well. You also will get a written plan (such as a checklist) when you leave, letting you know which screenings and other preventive services you should get. Depending on your general health and medical history, further tests may be ordered if necessary.

The Medicare initial preventive physical examination form can be found at: www.vimipro.org/Publications/pdf/medicarepreventiveexam.pdf or by calling 1-800-MEDICARE (1-800-633-4227).

Advance Directives

Starting in 2009, doctors began talking about end-of-life planning, including advance directives. Talking to your family, friends and health care providers about your wishes is important, but these legal documents ensure your wishes are followed.

TIP: You may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

MEDICARE SUPPLEMENT INSURANCE
SHOPPING TIPS

You May Not Need Medicare Supplement Insurance

If your income is low, you may qualify for a government program that will fill in the gaps in your Medicare coverage. Check with your local Welfare office to find out if you are eligible for **Medicaid** or if you are a **Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB)** or a **Qualified Individual (QI).**

One Policy is Enough

You do not need more than one policy. If you already have a policy and want better benefits, you can **replace** the policy with a new one. Once you receive the new policy you should drop the old one. **Caution:** Premiums paid in advance are sometimes non-refundable. Example: If you have paid for a one-year policy period and decide to cancel in the middle of the policy term, the premium may be earned when paid and there may be no provision for a refund of premium at any time during that policy period. See pages 16-21 and 45 for other tips and resources.

Right to Coverage

You have the right to buy any Medicare supplement policy on the market **if** you:

- have signed up for Medicare Part B within the past 6 months; **and**
- are 65 or older.

If you apply for a policy after that six-month period, some companies will reject your application if your health is not good. If you joined Medicare because of a disability before you turned 65, federal law now requires that you be given an open enrollment opportunity when you turn 65.

Shop for Benefits, Service and Price

Check the chart of the 10 plans on 24 to see the benefits that are included in each plan. Every company must use the same letters (A through N) to label its policies. Plan A will always be a company's lowest-priced Medicare supplement policy. It covers valuable basic benefits and must be sold by every company. Plans B through L add other benefits to fill different gaps in your Medicare coverage.

Use the Medicare Guide

The ***Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*** ("Guide"), written by the federal government and the National Association of Insurance Commissioners (NAIC), has excellent information about Medicare, as well as health insurance. Any agent or company that offers to sell you Medicare supplement insurance must give you a copy. Upon request, a copy of the Guide is also available from the Division of Insurance, the Division for Aging Services or the State Health Insurance Assistance Program ("SHIP").

Read the Outline of Coverage

The outline of coverage for Medicare supplement insurance includes more details about each of the benefits in the policy. The outline of coverage only describes the policy in general terms. You need to read the actual policy for the details of your coverage. When reviewing the policy, spend extra time studying the provisions about pre-existing conditions.

Evaluate Your New or Existing Policy

Before buying any new insurance, read your existing policy. Don't change policies just to get a lower price. Premiums can change, and a new policy may not remain less expensive than the old one. Ask yourself, **"Would a new policy really improve my health coverage?"** Perhaps your old policy can be updated to provide the additional coverage you want.

- **Ask** how an insurance company prices Medigap policies. The manner in which they set the price affects how much you pay now and in the future.

- **Ask** if there are factors other than age that may affect the cost of your Medigap policy. Policies may have discounts based on your sex, whether you smoke, whether you are married and/or if you have automatic bank withdrawal.

- **Ask** the reference section of your local public library for financial rating publications that summarize an insurance company's financial position. Some publications rate companies by letter grades, which can be informative. Four organizations are commonly relied upon to rate insurance companies: A.M. Best, Standard & Poor's (S&P), Moody's Investor

Service and Fitch Ratings. The role of these agencies is to assess the debt and financial strength of companies by providing a neutral analysis. In rating debt and financial strength, these agencies assist in judging a carrier's ability to meet their claims paying obligations. If an insurance company cannot pay future claims or benefits, all other considerations, such as coverage and pricing, become relatively unimportant.

- **Before joining a plan**, be sure to carefully read the plan's membership materials and enrollment forms to learn your rights and the nature and extent of your coverage. Remember, PPO plans pay less for any non-emergency claims from providers outside your service area.

- **Buying locally** from an agent with a good reputation is safer than buying from someone you do not know. A traveling agent may never return to your area. You also may want to discuss the policy with a relative, friend or someone else whom you trust before buying. When buying by mail, check whether the company has a local agent or a toll-free number that you can call for answers to your questions and for help in filing claims. Also, it is wise to consider factors other than price when selecting a policy, including claims handling and a company's reputation for service. Ask friends and family members about their experience with various companies.

- **Compare** before you buy. Shop around and talk to several agents and companies before making a decision. When shopping for a Medigap policy, be sure you are comparing the same policy. Do not be embarrassed to ask questions. Do not buy a policy until you are satisfied with the answers you receive. **Shop around with care.** Even the standardized plans may vary widely in cost.

- **Do not** pay cash or make a check out to the agent or in the agent's name. Checks should be made payable **only** to the insurance company. Get a receipt for all payments

- **Don't be misled** into believing that a Medicare supplement policy is endorsed by or sold by the state or federal government. Although the Division of Insurance reviews Medicare supplement policy forms to make sure they meet Nevada requirements, the Division does

not endorse particular companies or policies. It is a violation of federal and state law for insurance companies or agents to suggest they are acting on behalf of the government when selling Medicare supplement insurance.

- **Don't be pressured** to buy insurance on the agent's first visit. If you can, invite a trusted friend or relative to be present during the agent's visit. An agent who objects to this may not be the right agent for you.

- **Don't be stampeded** by statements that a certain policy or premium rate will be available only for a limited time. Such statements are seldom true.

- **Get** a copy of the policy.

- **Group coverage** is marketed through employers, labor unions and various private associations. If you have group insurance, ask before retirement if you can continue your employee health insurance or convert it to suitable group Medicare supplement coverage after you turn 65. Group insurance often costs less and is more comprehensive than individually purchased coverage. Also, if your spouse is included in your group health plan, be sure to check on his or her eligibility.

- **If you change policies,** remember that your pre-existing conditions are covered immediately when you have been covered for a total of six months under both policies.

- **Make sure** you really need Medicare supplement insurance before you buy. People who are eligible for Medicaid don't need Medicare supplement insurance. To find out if you are eligible for Medicaid, contact the State Department of Health and Human Services, Medicaid office at (775) 684-7200 in Northern Nevada, (702) 486-1646 in Southern Nevada or toll free: (800) 992-0900.

- **Take full advantage** of your "free look" period by carefully reviewing your new policy. You have 30 days <u>from the date you receive the policy</u> to return and cancel it for a full refund. Read the policy when it arrives; don't wait until the last minute. If you find it

difficult to understand, get help from a friend, relative or someone else you trust. Similarly, the Division of Insurance Consumer Services section can help you understand what your policy covers. Also, some senior citizen organizations have volunteer insurance advisors. See 44 for information regarding SHIP.

Completing the Application

- **Be careful** to answer all questions accurately. Don't let the agent fill out the application for you. If an agent helps you to complete the application, do not sign it until you are sure that all questions have been completely answered and all requested medical information is included and correct. The omission of information may cause the company to deny your claims or cancel your policy.

- **Be sure** you have the agent's name and address and the address of the company from which you are purchasing the policy. Know how to contact your agent or the company if you need help. It's also a good idea to check the license status of the agent and the insurance company with the Division of Insurance. You may also verify an insurance company on the Division's Web site at www.doi.nv.gov or through www.nvinsurancealert.com, an anti-fraud Web site coordinated by the Division along with the Nevada Surplus Lines Association and the Nevada Independent Insurance Agents.

- **Never sign** a blank application form.

- **Read** what you are being asked to sign. If the agent tries to rush you, be suspicious.

- **Remember**, if you are replacing policies, you should have full coverage for all pre-existing conditions when you have been covered for six months under the old policy, the new policy or both. This should be explained to you in a Replacement Notice provided by the new insurance company or its agent. If you return the policy to the company, be sure to send it by certified mail with a return receipt requested. This will give you a record of the date it was returned in case there is a dispute.

Special Information for Military Retirees

You or your spouse may be eligible for TRICARE for Life if either has retired from the United States military service. The benefits covered by TRICARE for Life supplement Medicare coverage eliminate the need for a Medicare supplement policy. In addition, TRICARE for Life benefits include coverage for outpatient prescription drugs not covered by Medicare. Unlike Medicare supplement policies, there is no enrollment fee to belong to TRICARE for Life. If you believe that you are eligible for this program you can contact the Defense Manpower Data Center Support Office (DSO) at (800) 538-9552.

More Information is Available

The Division of Insurance Consumer Services section is happy to answer any additional questions you might have. If you have more questions about Medicare supplement insurance, contact us at:

State of Nevada
Department of Business & Industry
Division of Insurance

Carson City Office (775) 687-0700; cscc@doi.state.nv.us
Las Vegas Office (702) 486-4009; cnsmvlv@doi.state.nv.us

Also, refer to pages 44 and 45 of this guide for free counseling and other resources.

COST COMPARISON AND GUIDE TO PREMIUM CHART

This section of the booklet has a graph outlining the 10 standard plans and offers a comparison of premiums by plan and company. Companies are listed in alphabetical order.

NOTICE
The policy comparison section summarizes material submitted by the insurers. The figures are theirs, not those of the Division of Insurance. Some information may not be current at the time you read this publication. The policy itself becomes the contract between the insurance company and you, and will be the basis of final determinations. Only policies that meet the requirements of Nevada laws and regulations at time of publication are included.

Publication of this comparison is for informational purposes only. Inclusion of information about a policy in this brochure does not in any way constitute endorsement of a policy or company by the Division of Insurance.

GUIDE TO THE PREMIUM COMPARISON CHART

Annual Premiums

The premiums shown are only a sampling of the 2010 annual rates. Additional information regarding the rates can be obtained from the insurance company. The rates may change every year as companies file new rates with the Division of Insurance. Some companies expect you to pay every month, others bill every two to three months, and some bill annually. While rates can change because of an insurance company's increased claims for all similar policyholders, your premiums cannot increase based on your individual claims.

Age Groups

Premiums are based on your age when you buy the policy. Although companies may have a different premium for each age, this comparison shows premiums at five-year intervals (age 65 and 70). It's important to remember that premiums will probably increase every year to keep up with Medicare changes. Companies also may increase premiums if overall claim expenses are higher than anticipated.

Premium Type

Companies have two different methods of pricing policies based on your age. These are shown in the "Prem Type" column.

- **Issue Age (I):** These policies are priced at your age when you initially purchase the policy. Your future rates will **not** increase because of age as you become older. If you buy the policy at age 65 you will always pay the premium that the company charges 65-year-old customers. However, your premiums can increase because of an insurance company's overall claims experience. While the initial rate for an **Issue Age (I)** policy may be greater than a similar **Attained Age (A)** policy, it could be less expensive over the life of the policy.

- **Attained Age (A):** In addition to the annual rate increases for changes in Medicare and overall claims experience, the premium will increase as you become older. If you buy a policy at 65, when you are 70 you will pay whatever the company is then charging individuals who are 70 years old.

- **No Age Rating (N):** The premium is the same for all customers who buy this policy, regardless of age.

Area

Some companies charge different premiums based on where you live.

Smoker

Some companies may charge different premiums for non-smokers and smokers. If this column has a **Y**, the company has two or more sets of prices. You should check with the company to find out if your premium would be higher or lower.

Sex

Premiums are shown for women. A company with an **N** in this column uses the same rates for both male and female. A company with a **Y** in this column has different (usually higher) premiums for men.

Health Screening / Underwriting

Although most companies underwrite, some offer policies regardless of any health problems you may now have.

2011 POLICY BENEFIT CHART

Medicare supplement insurance can be sold in only nine standard plans and one high-deductible plan. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in Nevada.

Plans E, H, I and J are no longer available for sale.

Basic Benefits:
Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B co-insurance or co-payments.
Blood - First three pints of blood each year.
Hospice - Part A co-insurance.

A	B	C	D	F	High Deductible F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 co-payment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible					
				Part B Excess 100%	Part B Excess 100%	Part B Excess 100%				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [$4,620]; paid at 100% after limit reached	Out-of-pocket limit [$2,310]; paid at 100% after limit reached		

*** Plan F also has an option called a high-deductible Plan F. This high-deductible plan pays the same benefits as Plan F after a calendar-year deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses equal to the annual deductible have been satisfied. Out-of-pocket expenses for this deductible are expenses that would ordinarily have been paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

2010 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 65

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										
						A	B	C	D	F	G	K	L	M	N	HDF
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	1,089				1,494		772	1,063			584
Anthem Blue Cruss & Blue Shield Nevada*	1-800-332-3842	A	Y	Y	6	1,274				1,764	1,641				1,217	617
Bankers Fidelity Life Insurance Company	1-800-241-1439	A/I	Y	N	0	1,188				1,644	1,152	672				576
Colonial Penn Life Insurance Company	1-800-800-2254	A	Y	N	0	1,421	1,680			1,835	1,689	738	1,171	1,502	1,065	440
Combined Insurance Company of America	1-800-544-5531	A	N	Y	0	1,165				1,664					1,165	
Equitable Life & Casualty Insurance Company	1-800-352-5170	A	Y	Y	0	1,552				2,198					1,547	
Gerber Life Insurance Company	1-877-778-0839	A	Y	Y	0	931				1,311	1,124					
Globe Life and Accident Insurance Company	1-800-801-6831	A	N	N	2	1,001	1,476	1,650		1,667						
Humana Insurance Company	1-800-310-8482	A	Y	Y	3	1,462	1,591	1,834		1,872		857	1,218			702
Liberty National Life Insurance Company*	1-800-331-2512	A	Y	Y	2	1,387	1,927			2,184					1,715	499
Medico Insurance Company	1-800-228-6080	A	Y	Y	0	895			1,201	1,312						
Physicians Mutual Insurance Company	1-800-228-9100	A/I	Y	N	0	846				1,508	1,152					451

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "Y" in either the Area Column or the Sex Column.

**** The company does offer Medicare Supplement policies to people under 65.***

2010 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 65

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										
						A	B	C	D	F	G	K	L	M	N	HDF
Royal Neighbors of America	1-866-845-6665	A	Y	Y	0	1,418				2,084	1,670					
SecureHorizons by UnitedHealthcare	1-800-768-1479	A	Y	N	0	1,188				1,598	1,441	757	1,041		1,071	515
Sentinel Security Life Insurance Company	1-800-247-1423	A	Y	Y	0	922	1,017	1,255	1,082	1,285						
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	1,900	2,163	2,460	1,482	2,023	1,493				975	294
State Farm Mutual Automobile Insurance Co.	1-866-855-1212	A	Y	N	0	1,380		2,082		2,103						
Sterling Investors Life Insurance Company	1-800-321-0102	A	Y	Y	0	1,093	1,277	1,520	1,338	1,588	1,345			1,204	1,111	625
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	1,014	1,199	1,553	1,297	1,559	1,335		959	1,214		510
United American Insurance Company*	1-800-331-2512	A	Y	N	2	1,252	1,807	2,057	1,897	2,069	1,907	1,211	1,705		1,616	471
UnitedHealthcare Insurance Company	1-800-523-5800	A	Y	N	3	1,031	1,372	1,575		1,583		626	873		1,158	
United of Omaha Life Insurance Company	1-800-865-2674	A	Y	Y	0	936				1,357	1,153			1,079	1,011	
United Teacher Associates Insurance Company	1-800-880-8824	A	Y	Y	6	961	1,121	1,342	1,175	1,391	1,205				973	
USAA Life Insurance Company	1-800-531-8722	A	N	N	0	1,212				1,803						

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "Y" in either the Area Column or the Sex Column.

*** The company does offer Medicare Supplement policies to people under 65.***

2010 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 70

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										
						A	B	C	D	F	G	K	L	M	N	HDF
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	1,220				1,673		865	1,191			654
Anthem Blue Cross & Blue Shield Nevada*	1-800-332-3842	A	Y	Y	6	1,535				2,106	1,959				1,453	737
Bankers Fidelity Life Insurance Company	1-800-241-1439	A/I	Y	N	0	1,320				1,836	1,356	792				648
Colonial Penn Life Insurance Company	1-800-800-2254	A	Y	N	0	1,736	2,045			2,224	2,080	900	1,403	1,857	1,377	534
Combined Insurance Company of America	1-800-544-5531	A	N	Y	0	1,523				2,175					1,523	
Equitable Life & Casualty Insurance Company	1-800-352-5170	A	Y	Y	0	1,665				2,369					1,670	
Gerber Life Insurance Company	1-877-778-0839	A	Y	Y	0	1,101				1,554	1,332					
Globe Life and Accident Insurance Company	1-800-801-6831	A	N	N	2	1,334	1,824	1,996		2,015						
Humana Insurance Company	1-800-310-8482	A	Y	Y	3	1,728	1,880	2,168		2,212		1,013	1,440			830
Liberty National Life Insurance Company*	1-800-331-2512	A	Y	Y	2	1,908	2,678			3,026	3,128				2,439	727
Medico Insurance Company	1-800-228-6080	A	Y	Y	0	1,009			1,373	1,485						
Physicians Mutual Insurance Company	1-800-228-9100	A/I	Y	N	0	982				1,776	1,359					592

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "Y" in either the Area Column or the Sex Column.

**** The company does offer Medicare Supplement policies to people under 65.***

2010 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 70

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										
						A	B	C	D	F	G	K	L	M	N	HDF
Royal Neighbors of America	1-866-845-6665	A	Y	Y	0	1,621				2,381	1,909					
SecureHorizons by UnitedHealthcare	1-800-768-1479	A	Y	N	0	1,389				1,925	1,759	894	1,256		1,348	655
Sentinel Security Life Insurance Company	1-800-247-1423	A	Y	Y	0	1,091	1,201	1,487	1,283	1,523						
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	1,948	2,218	2,521	1,519	2,073	1,531				1,000	301
State Farm Mutual Automobile Insurance Co.	1-866-855-1212	A	Y	N	0	1,725		2,603		2,629						
Sterling Investors Life Insurance Company	1-800-321-0102	A	Y	Y	0	1,300	1,517	1,818	1,591	1,867	1,600			1,433	1,307	734
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	1,559	1,372	1,777	1,485	1,782	1,527		1,096	1,388		583
United American Insurance Company*	1-800-331-2512	A	Y	Y	2	1,721	2,509	2,847	2,690	2,860	2,701	1,614	2,275		2,298	687
UnitedHealthcare Insurance Company	1-800-523-5800	A	Y	N	3	1,272	1,692	1,941		1,951		773	1,077		1,428	
United of Omaha Life Insurance Company	1-800-865-2674	A	Y	Y	0	1,089				1,579	1,342			1,255	1,176	
United Teacher Associates Insurance Company	1-800-880-8824	A	Y	Y	6	1,090	1,272	1,524	1,334	1,564	1,367				1,095	
USAA Life Insurance Company	1-800-531-8722`	A	N	N	0	1,418				2,111						

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "Y" in either the Area Column or the Sex Column.

**** The company does offer Medicare Supplement policies to people under 65.***

MEDICARE ADVANTAGE

Original fee-for-service Medicare and original Medicare with a Medicare supplement policy are available to all Nevada beneficiaries who are age 65 or older, who are under age 65 with certain disabilities and to people of all ages with End-Stage Renal Disease (Note that very few insurers offer Medicare supplement policies to beneficiaries under age 65). Under managed care plans, Medicare HMOs are currently available in six Nevada counties (Clark, Esmeralda, Lyon, Mineral, Nye and Washoe). The options available in the Medicare Advantage program are described on the following page and include:

Anthem Blue Cross and Blue Shield Local PPO – Clark and Washoe Counties
CareMore Health Plan of Nevada Local HMO – Clary County
CareMore Health Plan of Nevada Special Needs Plan (SNP) – Clark County
Health Plan of Nevada, Inc. HMO with POS option – Clark, Esmeralda, Lyon, Mineral, Nye and Washoe Counties
Health Plan of Nevada Inc. SNP – Clark and Nye Counties
Humana Health Plan, Inc. Local HMO – Clark and Nye Counties
Humana Health Plan, Inc. HMO with POS option – Clark and Nye Counties
Humana Health Plan, Inc. SNP – Clark, Nye and Washoe Counties
Humana Insurance Company Local PPO – Clark, Nye and Washoe Counties
Humana Insurance Company PFFS – Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, Storey and White Pine Counties
SecureHorizons by UnitedHealthcare PFFS – Clark County
Senior Care Plus Local HMO – Washoe County
Senior Care Plus Local PPO – Washoe County
Sierra Health and Life Insurance Company, Inc. Regional PPO – All counties
Universal American PFFS – Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, Storey and White Pine Counties
Universal Health Care Insurance Company, Inc. PFFS – Carson City, Churchill, Clark, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, Storey, Washoe and White Pine Counties
Universal Health Care of Nevada, Inc. – Clark County

Original Medicare is the traditional fee-for-service Medicare and is available to all Medicare beneficiaries. Medicare Part A (hospital insurance) is available to all eligible Medicare beneficiaries without a monthly premium. You have the option to pay a premium for Medicare Part B (medical insurance) to receive those benefits. For 2010, the Medicare Part B premium is $115.40 per month. Under traditional Medicare, you can choose any health care provider who accepts Medicare. Medicare pays the provider each time you incur an expense. While Medicare pays its portion, you are responsible for paying the balance including deductibles, co-payments, co-insurance and the cost of services not covered by Medicare.

All newly enrolled Medicare beneficiaries are covered for an initial physical examination and for cardiovascular screening blood tests. People considered "at risk" are covered for a diabetes screening test for early detection and treatment of this life-threatening condition.

Original Medicare with a Supplement Policy

You can purchase a private Medicare supplement insurance plan (also referred to as "Medigap insurance") to cover some of your obligations after traditional Medicare has paid its portion. You may purchase one of 10 standard Medicare supplemental insurance policies (Medigap or Medicare SELECT described below). The benefits provided by these plans are summarized on the policy benefit chart found on page 24. Most policies pay Medicare co-insurance amounts while others pay Medicare deductibles. Some beneficiaries may already have supplemental coverage from other sources such as a former employer or Medicaid.

- **Medigap:** You can go to any doctor or hospital.
- **Medicare SELECT:** These plans are almost identical to standard Medigap insurance. When you purchase one of Medicare's SELECT policies, you're buying a standard Medigap plan. The only difference is that this type of plan operates like managed care plans. In other words, you **must** use plan hospitals and, in some cases, plan doctors in order to be eligible for full Medigap benefits.

Managed Care

Under a managed care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) offer comprehensive, coordinated medical services on a pre-paid basis.

You pay the Part B monthly premium of $115.40 and Medicare makes a monthly payment to the plan. Some plans charge you an extra monthly premium. You may also be required to pay a co-payment per visit or service. The monthly premiums and co-payments will vary depending on the plan you choose and the county in which you live. A supplemental insurance policy is not necessary if you join a managed care plan.

- **HMO:** In a Health Maintenance Organization, you **must** use the plan's providers (doctors, hospitals, skilled nursing facilities and ancillary providers). These providers are paid directly by the HMO and you are only required to make small co-payments ($5 to $10 per visit). These plans offer services that are not covered by traditional fee-for-service Medicare.

- **HMO with POS option:** Less restrictive than HMOs. When combined with a basic HMO package, the POS (point-of-service) option allows you to use doctors and hospitals outside of the plan for an additional cost.

- **PSO:** In a Provider Sponsored Organization you **must** use the plan's providers. These plans operate like an HMO; however, the plan is sponsored by the providers (doctors and/or hospitals).

- **PPO:** The in-network benefits are provided by the plan's providers (preferred providers). However, you can use doctors and hospitals outside of the plan for an additional cost.

Private Fee-for-Service Plan

In a private fee-for-service plan, you select a private insurance plan which accepts Medicare beneficiaries. You pay the Part B premium, any other monthly premium the private fee-for-service plan charges, and an amount per visit or service. While the plan, not Medicare, determines how much to allow for the service, the provider is allowed to charge more than the allowed amount and bill you for the difference. The plan may provide extra benefits that traditional Medicare does not cover.

Health Savings Account (HSA)

Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families; and are open to anyone who enrolls in a high-deductible health insurance plan. However, if you are on Medicare or if you receive benefits from the Department of Veterans Affairs, you cannot set up an HSA. For 2011, the high-deductible plan must have an annual deductible of at least $1,200 for

individual coverage and at least $2,400 for family coverage, with a maximum out-of-pocket of $5,950 and $11,900, respectively. Total yearly contributions to an HSA can be up to the lesser of deductible or $3,050 for individual coverage and up to the lesser of deductible or $6,150 for family coverage.

HSAs fall under the jurisdiction of the United States Department of Treasury. If an individual ceases to be eligible or makes an ineligible withdrawal, penalties and taxes may apply. For assistance with HSAs, please contact your HSA trustee or visit the United States Department of the Treasury's Web site at www.treas.gov and click on Health Savings Accounts.

MEDICARE HMOs

An HMO that has a contract with Medicare must provide or arrange for the full range of Part A and B services if you are covered under both parts of Medicare. HMOs can also provide benefits beyond what Medicare allows, such as preventive care, prescription drugs (limited amount), dental care, hearing aids, and eyeglasses.

Before joining a plan, be sure to read the plan's membership materials and enrollment forms carefully to learn your rights and the nature and extent of your coverage. If you belong to an HMO plan, the plan will not pay claims for any non-emergency benefits you receive from providers outside of the HMO. Below is a list of Medicare HMOs offered in Nevada.

Clark County:

CareMore Health Plan of Nevada (CareMore Value Plus)	(800) 499-2793
CareMore Health Plan of Nevada (StartSmart with CareMore)	(800) 499-2793
Health Plan of Nevada, Inc. (HPN) (Senior Dimensions Southern Nevada)	(800) 274-6648
Humana Health Plan, Inc. (Humana Gold Plus HMO & HMO-POS)	(800) 833-0632
SecureHorizons by UnitedHealthcare (SecureHorizons MedicareComplete)	(800) 577-5623
Universal Health Care of Nevada, Inc. (e-Medicare Masterpiece Direct)	(800) 965-7034
Universal Health Care of Nevada, Inc. (Medicare Masterpiece)	(800) 965-7034

Esmeralda County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions Greater Nevada)	(800) 274-6648

Lyon County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions Greater Nevada)	(800) 274-6648

Mineral County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions Greater Nevada)	(800) 274-6648

Nye County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions Southern Nevada)	(800) 274-6648
Humana Health Plan, Inc. (Humana Gold Plus HMO & HMO-POS)	(800) 833-0632

Washoe County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions Greater Nevada)	(800) 274-6648
Hometown Health Plan (Senior Care Plus: Value Rx Enhanced Plan)	(800) 336-0123
Hometown Health Plan (Senior Care Plus: Value Rx Plan)	(800) 336-0123
Hometown Health Plan (Senior Care Plus: Value Rx Premier Plan)	(800) 336-0123
Hometown Health Plan (Senior Care Plus: Value Rx Select)	(800) 336-0123
Hometown Health Plan (Senior Care Plus: Value Basic Plan)	(800) 336-0123

2011 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART

(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	SENIOR DIMENSIONS Southern Nevada SHMO (Clark and Nye County)	SENIOR DIMENSIONS Greater Nevada (HMO) Medicare Advantage (Washo zip code specific, Lyon, Mineral, Esmeralda Counties)
			1/1/2011 - 12/31/2011	1/1/2011 - 12/31/2011
		YOU PAY:	YOU PAY:	YOU PAY:
Premium		$96.40 Part B	$0 plus $96.40 Part B Premium (No Premium Credit in 2011)	$0 plus $96.40 Part B Premium (No Premium Credit in 2011
Hospital Care	1 to 60 days	**$1,068**	Day 1 - 7 $125 per day	Day 1 - 7 $200 per day
	61 to 90	**$267 a day**	Day 8 - 90 $0 per day	Day 8 - 90 $0 per day
	91 to 150	**$534 a day**	$0	$0
	Beyond 150	**All costs**	$0	$0
Doctors Visits	Per Visit	**20% plus***		
Primary Care/Specialist	Deductible	**$135**	$5PCP/$25Specialist (POS)$35.	$15PCP/$35Specialist
Prescription Copayment	Pharmacy - 31 days	**Full**	$0 Generic Drugs, $6 Preferred Generic, $38 Preferred Brand $92 Non-Preferred 33% Specialty Drug same as above	$$5 Generic, $6 Preferred Generic, $44 Preferred Brand, $93 Non-Preferred, 33% Specialty Drug same as above
Generic/Brand Name	Mail Order - 90 days	**Amount**	90-day supply from plan mail order vendor $0 Generic, $12 Preferred Generic, $104 Preferred Brand, 33%Specialty Drug 90-day supply at retail pharmacy for $ 0 Generic, $18 Preferred Generic, $114 Preferred Brand, 33% Specialty Drug	90-day supply from plan mail order vendor $10 Generic, $12 Preferred Generic, $122 Preferred Brand, 33%Specialty Drug 90-day supply at retail pharmacy for $15, Generic, $18 Preffered Generic, $132 Preferred Brand, 33% Specialty Drug
Coverage Gap			(Coverage gap up to 99% Generic and less than 10% of Preferred Brand)	(Coverage gap up to 99% Generic and less than 10% of Preferred Brand)
Annual Limit			After your yearly total drug costs reach $4,550 you pay the greater of: $2.50 for Generic or a Preferred Brand drug that is a multi-source drug, $6.30 for all other drugs or 5% coinsurance	After your yearly total drug costs reach $6,440 you pay the greater of: $2.50 for Generic or a Preferred Brand drug that is a multi-source drug, $6.30 for all other drugs or 5% coinsurance
Out of	Urgent Care	**NA**	$25 plan facility; $40 non-plan	$30 plan facility, $40 non-plan
Plan Svs.	Emergency Care	**NA**	$50	$50
Phone Number:			Existing Members:702-242-7301 or 800-650-6232 (TTY 702-242-9214 or 800-349-3538) Prospective members: 702-821-2300 or 800-274-6648, (TTY 702-242-9214 or 800-349-3538)	Existing Members:702-242-7301 or 800-650-6232 (TTY 702-242-9214 or 800-349-3538) Prospective members: 775-824-9703 or 800-753-0669 (TTY 702-242-9214 or 800-349-3538)

2011 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	Humana, Inc. (LPPO) Clark & Nye Counties	Humana, Inc. (LPPO) Washoe County
		YOU PAY:	HumanaChoice PPO H9503-001	HumanaChoice PPO H9503-003
			In 2011 YOU PAY:	In 2011 YOU PAY:
Premium		**$96.40 Part B**	$116 plus Part B Premium	$61 plus Part B Premium
Hospital Care	1 to 60 days	**$1,132**	$195 copay/day Days1-7 IN; $250 copay/day Days 1-7 OON	$550 Copay/admit IN; $800 Copay/admit OON
	61 to 90 days	**$283 a day**	$0	$0
	91 to 150 days**	**$566 a day**	$0	$0
	Beyond 150 days	**All costs**	$0	$0
Doctor Visits	Per Visit	**20% plus***	$10 PCP/ $35 Spec IN; 30% OON	$10 PCP/ $25 Spec IN; 30% OON
(Primary Care & Specialists	Deductible	**$162**	$500 OON Services Only Services not covered Original Medicare, Ambulance services, Emergency Room services, and Immunizations (Flu and Pneumonia) do not apply to the OON deductible.	$0
Prescription Copayment	Deductible	**N/A**	$0	$0
(Generic & Brand)	Retail Pharmacy (30 days)	**N/A**	Tier 1- Preferred Generic - $7	Tier 1- Preferred Generic - $6
		N/A	Tier 2- Preferred Brand - $42	Tier 2- Preferred Brand - $39
		N/A	Tier 3- Non-preferred brand/generic - $80	Tier 3- Non-preferred brand/generic - $80
		N/A	Tier 4- Specialty - 33%	Tier 4- Specialty - 33%
	Preferred Mail Order (90 Days)	**N/A**	Tier 1- Preferred Generic - $0	Tier 1- Preferred Generic - $0
		N/A	Tier 2- Preferred Brand - $116	Tier 2- Preferred Brand - $107
		N/A	Tier 3- Non-preferred brand/generic - $230	Tier 3- Non-preferred brand/generic - $230
Annual Prescription			Initial Coverage Limit at $2,840 total drug expenditure	Initial Coverage Limit at $2,840 total drug expenditure
Catastrophic Rx Coverage			True Out-of-Pocket Costs $4,550.00 Member pays the greater of $2.50 for generic/preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.	True Out-of-Pocket Costs $4,550.00 Member pays the greater of $2.50 for generic/preferred multi source drugs and $6.30 for all other drugs; OR 5% coinsurance.
Out-of-Plan Services	Urgent Care	**N/A**	$10 PCP/ $35 Spec IN; 30% OON	$10 PCP/ $25 Spec IN; 30% OON
	Emergency Care	**N/A**	$50 copay waived if admitted within 24 hours IN/OON	$50 copay waived if admitted within 24 hours IN/OON
Phone Numbers	**Members (800) 457- 4708 or (800) 633 - 4227**			

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.
** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2011 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	Humana, Inc. (HMO) Partial Clark County and Partial Nye County		
		YOU PAY:	Partial Clark and Nye Counties Humana Gold Plus HMO H2949-009	Partial Clark and Nye Counties Humana Gold Plus HMO H2949-012	Partial Clark and Nye Counties *** Humana Gold Plus HMO-SNP H2949-013
			In 2011 YOU PAY:		
Premium		**$96.40 Part B**	$0 plus Part B Premium	$0 plus Part B Premium	$0 plus Part B Premium
Hospital Care	1 to 60 days	**$1,132**	$50 Copay/day - Days 1-5	$50 Copay/day - Days 1-5	$50 Copay/day - Days 1-5
	61 to 90 days	**$283 a day**	$0	$0	$0
	91 to 150 days**	**$566 a day**	$0	$0	$0
	Beyond 150 days	**All costs**	$0	$0	$0
Doctor Visits	Per Visit	**20% plus***	$0 PCP / $30 Spec	$0 PCP / $30 Spec	$0 PCP / $10 Spec
(Primary Care & Specialists)	Deductible	**$162**	$0	$0	$0
Prescription Copayment	Deductible	**N/A**	$0	$0	$0
(Generic & Brand)	Retail Pharmacy	**N/A**	MA-ONLY	Tier 1- Preferred Generic - $6	Tier 1- Preferred Generic - $5
	(30 days)	**N/A**		Tier 2- Non-preferred Generic/ Preferred Brand - $38	Tier 2- Preferred Generic/Brand - $5
		N/A		Tier 3- Non-preferred brand - $80	Tier 3- Non-preferred Generic/ Preferred Brand - $40
		N/A		Tier 4- Specialty - 33%	Tier 4- Non-Preferred Brand - $80
					Tier 5- Specialty - 33%
	Preferred Mail Order	**N/A**		Tier 1- Preferred Generic - $0	Tier 1- Preferred Generic - $0
		N/A		Tier 2- Preferred Brand - $104	Tier 2- Preferred Generic/Brand - $0
	(90 Days)	**N/A**		Tier 3- Non-preferred brand/generic - $230	Tier 3- Non-preferred Generic/ Preferred Brand - $110
					Tier 4- Non-Preferred Brand - $230
Annual Prescription Coverage Limit			N/A	Initial Coverage Limit at $2,840 total drug expenditure	Initial Coverage Limit at $2,840 total drug expenditure
Catastrophic Rx Coverage			N/A	After $4,550 member's out-of-pocket copayments would be greater of $2.50 for generic & preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.	After $4,550 member's out-of-pocket copayments would be greater of $2.50 for generic & preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	**N/A**	$0 PCP / $30 Spec	$0 PCP / $30 Spec	$0 PCP / $10 Spec
	Emergency Care	**N/A**	$50 copay not waived if admitted	$50 copay not waived if admitted	$50 copay not waived if admitted
Phone Numbers			**Members (800) 457- 4708 or (800) 633- 4227**		

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.

** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2011 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART

(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	Humana, Inc. (HMO) Partial Clark County and Partial Nye County	
		YOU PAY:	Partial Clark and Nye Counties *** Humana Gold Plus HMO-SNP H2949-014	Partial Clark and Nye Counties Humana Gold Plus HMO-POS H2949-015
			In 2011 YOU PAY:	
Premium		**$96.40 Part B**	$0 plus Part B Premium	$81 plus Part B Premium
Hospital Care	1 to 60 days	**$1,132**	$50 Copay/day - Days 1-5	$175 Copay/day - Days 1-6 IN; $275 Copay/day - Days 1-6 OON
	61 to 90 days	**$283 a day**	$0	$0
	91 to 150 days**	**$566 a day**	$0	$0
	Beyond 150 days	**All costs**	$0	$0
Doctor Visits	Per Visit	**20% plus***	$0 PCP / $10 Spec	$10 PCP / $25 Spec IN; $35 OON
(Primary Care & Specialists)	Deductible	**$162**	$0	$0
Prescription Copayment	Deductible	**N/A**	$0	$0
(Generic & Brand)	Retail Pharmacy	**N/A**	Tier 1- Preferred Generic - $5	Tier 1- Preferred Generic - $7
	(30 days)	**N/A**	Tier 2- Preferred Generic/Brand - $5	Tier 2- Non-preferred Generic/ Preferred Brand - $42
		N/A	Tier 3- Non-preferred Generic/ Preferred Brand - $40	Tier 3- Non-preferred brand - $80
		N/A	Tier 4- Non-Preferred Brand - $80	Tier 4- Specialty - 33%
			Tier 5- Specialty - 33%	
	Preferred Mail Order	**N/A**	Tier 1- Preferred Generic - $0	Tier 1- Preferred Generic - $0
		N/A	Tier 2- Preferred Generic/Brand - $0	Tier 2- Preferred Brand - $116
	(90 Days)	**N/A**	Tier 3- Non-preferred Generic/ Preferred Brand - $110	Tier 3- Non-preferred brand/generic - $230
			Tier 4- Non-Preferred Brand - $230	
Annual Prescription			Initial Coverage Limit at $2,840 total drug expenditure	Initial Coverage Limit at $2,840 total drug expenditure
Catastrophic Rx Coverage			After $4,550 member's out-of-pocket copayments would be greater of $2.50 for generic & preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.	After $4,550 member's out-of-pocket copayments would be greater of $2.50 for generic & preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	**N/A**	$0 PCP / $10 Spec	$10 PCP / $25 Spec IN; $35 OON
	Emergency Care	**N/A**	$50 copay not waived if admitted	$50 copay not waived if admitted IN/OON
Phone Numbers			**Members (800) 457- 4708 or (800) 633- 4227**	

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.
** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2011 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

		YOU PAY:	Statewide
			Humana Gold Choice PFFS H2944 - 053
			In 2011 YOU PAY:
Premium		**$96.40 Part B**	$171 plus Part B Premium
Hospital Care	1 to 60 days	**$1,132**	$225 copay/day - Days 1-7
	61 to 90 days	**$283 a day**	$0
	91 to 150 days**	**$566 a day**	$0
	Beyond 150 days	**All costs**	$0
Doctor Visits	Per Visit	**20% plus***	$15 PCP / $35 Spec
(Primary Care & Specialists)	Deductible	**$162**	$0
Prescription Copayment	Deductible	**N/A**	$310
(Generic & Brand)	Retail Pharmacy (30 days)	**N/A**	Tier 1- Preferred Generic - 25% Coinsurance
		N/A	Tier 2- Preferred Brand - 25% Coinsurance
		N/A	Tier 3- Non-preferred brand/generic - 25% Coinsurance
		N/A	Tier 4- Specialty - 25% Coinsurance
	Preferred Mail Order (90 Days)	**N/A**	Tier 1- Preferred Generic - 25% Coinsurance
		N/A	Tier 2- Preferred Brand - 25% Coinsurance
		N/A	Tier 3- Non-preferred brand/generic - 25% Coinsurance
Annual Prescription Coverage Limit			Initial Coverage Limit at $2,840 total drug expenditure
Catastrophic Rx Coverage			After $4,550, member's out-of-pocket copayments would be greater of $2.50 for generic & preferred multi-source drugs and $6.30 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	**N/A**	$15 PCP / $35 Spec
	Emergency Care	**N/A**	$50 copay not waived if admitted
Phone Numbers		**Members (800) 457- 4708 or (800) 633 - 4227**	

* You pay 20 percent of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.
** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2011 MEDICARE ADVANTAGE* BENEFITS COMPARISON CHART

(For use in the 2011 Medicare Supplement and Premium Comparison Guide)

			Traditional Medicare	SENIOR CARE PLUS Value Basic Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Plan (HMO) (Hometown Health Plan) Washoe County
			YOU PAY:	YOU PAY: $0 plus $66.40 Part B Premium =$66.40	YOU PAY: $0 plus $96.40 Part B Premium= $96.40
Premium			$96.40 Part B	*(includes $30 Part B Premium Rebate)*	
Hospital Care		1 to 60 days	**$1,100**	$150 per day for 1-5 days (unlimited days)***	$150 per day for 1-5 days (unlimited days)***
		61 to 90	**$275 a day**	$0	$0
		91 to 150	**$550 a day**	$0	$0
		Beyond 150	**All costs**	$0	$0
Doctors Visits		Per Visit	**20% plus****	$10/$40	$10/$40
Primary Care/Specialist		Deductible	**$155**	$0	$0
Prescription Copayment		Pharmacy - 30 days	**Full**	No	Formulary $4/$10/$40/$70
Generic/Preferred Brand/ Non-Preferred Brand Name		Mail Order - 90 days	**Amount**	Coverage	Formulary $10/$25/$100/$175
Annual Limit					all generic drug coverage in the gap
Out-of-	Urgent Care		**NA**	$25/$50 (anywhere in United States)	$25/$50 (anywhere in United States)
Plan Svs.	Emergency Care		**NA**	$50 (worldwide)	$50 (worldwide)
Other	Vision	VSP	**NA**	$20 Exam / 100% Lenses / $100 Frames	$20 Exam / 100% Lenses / $100 Frames
Other	Dental	Ameritas	**NA**	No Coverage	No Coverage
Other	Fitness Benefit	Silver&Fit	**NA**	Fitness Club Membership Included	Fitness Club Membership Included
Phone Number:				(775) 982-3158	

			Traditional Medicare	SENIOR CARE PLUS Value Rx Enhanced Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Select Plan (HMO) (Hometown Health Plan) Washoe County
			YOU PAY:	YOU PAY: $24 plus $96.40 Part B Premium= $120.40	YOU PAY: $70 plus $96.40 Part B Premium= $166.40
Premium			$96.40 Part B		
Hospital Care		1 to 60 days	**$1,100**	$150 per day for 1-4 days (unlimited days)***	$100 per day for 1-3 days (unlimited days)***
		61 to 90	**$275 a day**	$0	$0
		91 to 150	**$550 a day**	$0	$0
		Beyond 150	**All costs**	$0	$0
Doctors Visits		Per Visit	**20% plus****	$10/$40	$10/$35
Primary Care/Specialist		Deductible	**$155**	$0	$0
Prescription Copayment		Pharmacy - 30 days	**Full**	Formulary $3/$8/$40/$70	Formulary $2/$6/$40/$70
Generic/Preferred Brand/ Non-Preferred Brand Name		Mail Order - 90 days	**Amount**	Formulary $7.50/$20/$100/$175	Formulary $5/$15/$100/$175
Annual Limit				all generic drug coverage in the gap	all generic drug coverage in the gap
Out-of-	Urgent Care		**NA**	$25/$50 (anywhere in United States)	$20/$40 (anywhere in United States)
Plan Svs.	Emergency Care		**NA**	$50 (worldwide)	$50 (worldwide)
Other	Vision	VSP	**NA**	$20 Exam / 100% Lenses / $125 Frames	$20 Exam / 100% Lenses / $150 Frames
Other	Dental	Ameritas	**NA**	Preventive Dental Included	Comprehensive Dental Included - $1,500 Max
Other	Fitness Benefit	Silver&Fit	**NA**	Fitness Club Membership Included	Fitness Club Membership Included
Phone Number:				(775) 982-3158	

			Traditional Medicare	SENIOR CARE PLUS Value Rx Premier Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Freedom Rx Premier Plan (PPO) (Hometown Health Plan) Washoe County
			YOU PAY:	YOU PAY: $140 plus $96.40 Part B Premium= $236.40	YOU PAY:
Premium			$96.40 Part B		$185 plus $96.40 Part B Premium= $281.40
Hospital Care		1 to 60 days	**$1,100**	$50 per day for 1-3 days (unlimited days)***	$50 per hospital admission (in -network)***
		61 to 90	**$275 a day**	$0	$0
		91 to 150	**$550 a day**	$0	$0
		Beyond 150	**All costs**	$0	$0
Doctors Visits		Per Visit	**20% plus****	$10/$30	$10/$20 (in -network)
Primary Care/Specialist		Deductible	**$155**	$0	$0
Prescription Copayment		Pharmacy - 30 days	**Full**	Formulary $2/$4/$35/$65	Formulary $2/$4/$30/$60
Generic/Preferred Brand/ Non-Preferred Brand Name		Mail Order - 90 days	**Amount**	Formulary $5/$10/$87.50/$162.50	Formulary $5/$10/$75/$150
Annual Limit				all generic and some brand coverage in the gap	all generic and some brand coverage in the gap
Out-of-	Urgent Care		**NA**	$15/$30 (anywhere in United States)	$10/$20 (anywhere in United States)
Plan Svs.	Emergency Care		**NA**	$50 (worldwide)	$50 (worldwide)
Other	Vision	VSP	**NA**	$15 Exam / 100% Lenses / $200 Frames	$15 Exam / 100% Lenses / $200 Frames
Other	Dental	Ameritas	**NA**	Comprehensive Dental Included - $2,500 Max	Comprehensive Dental Included - $2,500 Max
Other	Fitness Benefit	Silver&Fit	**NA**	Fitness Club Membership Included	Fitness Club Membership Included
Phone Number:				(775) 982-3158	

* Medicare + Choice has changed its name to Medicare Advantage

** You pay 20 percent of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

*** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a service period or within 30 days of last discharge.

MEDICARE PPOs

A Medicare PPO Plan has a list (called a "network") of primary care doctors, specialists and hospitals that you may go to. You can visit any doctor, specialist or hospital not on the plan's list, but it usually will cost more. Some Medicare PPO plans offer prescription drug coverage and additional benefits, such as vision and hearing screenings, disease management, and other services not covered under the original Medicare plan. Monthly premiums and how much you pay for services vary depending on the plan. There is an annual limit on your out-of-pocket costs that varies depending on the plan.

The new regional PPOs serve 26 regions across the United States, including all rural areas. Nevada is in region 22. All regional PPO plans must offer the same benefits as traditional fee-for-service Medicare with simplified cost-sharing and new protections against catastrophic costs.

HIGH-DEDUCTIBLE PLANS

The annual deductible for the High-Deductible Plan F is $2,000[1]. Other than the deductible amount, this plan has the same coverage as a regular Plan F. Benefits under this plan will not begin until the out-of-pocket expenses have reached $2,000. The expenses not paid are the amounts the policy would have paid under regular Plan F, including the Medicare deductibles for Part A and Part B, but not the separate deductible for emergency foreign travel in Plan F. The premium for this plan is significantly less than the regular Plan F. At this time, there are twelve insurers offering high-deductible plans (based on the insurers voluntarily participating in this Guide). The following are the names and telephone numbers for these insurers:

Company	Telephone Number	High Deductible Plan
American Republic Corp Insurance Company	1-888-755-3065	Plan F
Anthem Blue Cross & Blue Shield Nevada	1-800-332-3842	Plan F
Bankers Fidelity Life Insurance Company	1-800-241-1439	Plan F
Colonial Penn Life Insurance Company	1-800-800-2254	Plan F
Humana Insurance Company	1-800-310-8482	Plan F

[1] The high deductible amount of $1,500 was initially established in 1999. This amount is adjusted annually by the United States Department of Health and Human Services.

Liberty National Life Insurance Company	1-800-331-2512	Plan F
Physicians Mutual Insurance Company	1-800-228-9100	Plan F
SecureHorizons by UnitedHealthcare	1-800-768-1479	Plan F
Standard Life and Accident Insurance Company	1-888-350-1488	Plan F
Sterling Investors Life Insurance Company	1-800-321-0102	Plan F
Thrivent Financial for Lutherans	1-800-847-4836	Plan F
United American Insurance Company	1-800-331-2512	Plan F

Plans K and L

Plans K and L provide for different cost-sharing for items and services than Plans A – G and M and N. Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You are responsible for paying excess charges.

GUARANTEED ISSUE

Certain people will have a right to **guaranteed issue of a Medicare supplement plan. In order to be eligible for guaranteed issue under any of these six circumstances mentioned below, you must apply within 63 days after losing your other health plan coverage.** The conditions for guaranteed issue are as follows:

1. When an employer terminates a group plan or eliminates substantially all supplemental benefits, an individual is eligible for Plans **A, B, C, F (including F with a high deductible), K or L.**

2. When a group plan is primary to Medicare and either the plan terminates or an individual leaves the plan, the individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

3. An individual who has a Medicare SELECT supplemental policy or is enrolled in a Medicare Advantage plan under Medicare (managed care or private fee-for-service, see pages 29 - 31), and discontinues the coverage because:
   a. The plan terminates or no longer provides service in the individual's area of residence;
   b. The individual is no longer eligible for the plan due to a change in residence; or
   c. The individual can show that the plan:
      1) Violated a material provision of the contract; or
      2) The agent for the plan materially misrepresented the plan.

   The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

4. An individual who is enrolled in a Medicare supplement plan and the coverage ceases because:
   a. The insurer becomes insolvent;
   b. Other involuntary terminations occur;
   c. The insurer violated a material provision of the contract, or;
   d. The insurer or agent materially misrepresented the plan.

   The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

5. An individual who terminates a Medicare supplement plan in order to sign up for a Medicare SELECT supplemental policy or a plan under Medicare Advantage (managed care or private fee-for-service, see pages 29 - 31), and then terminates the new coverage within 12 months, is **eligible for the same plan** the individual had prior to the change.

6. An individual who becomes eligible for the first time and signs up for Medicare Advantage and terminates this coverage within 12 months is **eligible for any plan.**

MEDICARE SHIP PROGRAM

The State Health Insurance Assistance Program (SHIP) is funded by a grant from the federal government and administered by the Nevada Department of Health and Human Services, Division for Aging Services.

The Program meets one of the most universal and critical needs of seniors and Medicare beneficiaries today: **free** one-on-one assistance and counseling for questions and problems regarding Medicare and supplemental health insurance. SHIP provides the following services:

- Pre-Medicare counseling;
- Information and eligibility on Medicare entitlements, benefits, limitations, Medicaid (Qualified Medicare Beneficiaries & Specified Low Income Medicare Beneficiaries), and Managed Care Plans through Health Maintenance Organizations (HMOs);
- Assistance with claims, requests for reconsideration and appeals processes under Medicare and supplemental insurance;
- Unbiased information that will assist the consumer in determining supplemental insurance and long-term care insurance needs;
- Outreach information and materials for seniors and families through meetings, seminars, classes, health fairs, senior fairs and the media **(speakers available);** and
- Referrals for coordination with federal and other state and community services.

Arrangements may be made for homebound seniors who need personal counseling assistance.

The services offered by the Program are **free of charge and confidential** and senior citizens are assured there will be no selling or soliciting for insurance. For additional information on SHIP or for individual counseling, please call:

(702) 486-3478 in Las Vegas; and

for statewide counseling call toll free 1-800-307-4444

MEDICARE COUNSELING PROGRAM

The following is a list of Senior Centers and/or local numbers to contact for counseling with the Nevada State Health Insurance Assistance Program (SHIP):

PLEASE CONTACT THE CENTER FOR COUNSELING TIMES
AND ADDITIONAL INFORMATION

Alamo	(775) 725-3340	Lovelock	(775) 273-2291
Amargosa	(775) 372-5413	McDermitt	(775) 532-8259
Austin	(775) 964-2338	Mesquite	(702) 346-5290
Battle Mountain	(775) 635-5311	Mina	(775) 573-2344
Beatty	(775) 553-2954	Moapa	(702) 865-2787
Boulder City	(702) 293-3320	Overton	(702) 397-8002
Caliente	(775) 726-3740	Owyhee	(775) 757-3174
Carlin	(775) 754-6465	Pahrump	(775) 727-5008
Carson City	(775) 883-0703	Panaca	(775) 728-4477
Crescent Valley	(775) 468-0466	Pioche	(775) 962-5378
Dayton	(775) 246-6210	Reno	(775) 328-2575
Duckwater	(775) 863-0155	Schurz	(775) 773-2224
Elko	(775) 738-5911	Searchlight	(702) 297-1614
Ely	(775) 289-2742	Silver Springs	(775) 577-5014
Eureka	(775) 237-5597	Sparks	(775) 353-3110
Fallon	(775) 423-7096	Sun Valley	(775) 673-9417
Fernley	(775) 575-3370	Tonopah	(775) 482-6450
Gardnerville	(775) 783-6455	Virginia City	(775) 847-0957
Gerlach	(775) 557-2206	Wells	(775) 752-3280
Hawthorne	(775) 945-5519	Winnemucca	(775) 623-6211
Henderson	(702) 565-6990	Yerington	(775) 463-6550
Laughlin	(702) 298-2592	Zephyr Cove	(775) 588-5140

Las Vegas: For counseling sites in the Las Vegas area, please call the SHIP program at (702) 486-3478

THE SERVICE OFFERED BY THE MEDICARE SHIP PROGRAM
IS PROVIDED BY TRAINED VOLUNTEERS/ADVISORS
AND IS **FREE** OF **CHARGE**

OTHER RESOURCES

Division of Insurance
(702) 486-4009 or (775) 687-0700 or Toll-Free: (888) 872-3234
www.doi.nv.gov

Centers for Medicare & Medicaid Services (CMS)
(410) 786-3000 or Toll-Free: (877) 267-2323
www.cms.hhs.gov

Social Security Administration (SSA)
(800) 772-1213
www.ssa.gov

National Association of Insurance Commissioners (NAIC)
(816) 842-3600
www.naic.org

Public Employees' Retirement System of Nevada (PERS)
(775) 687-4200 or Toll-Free: (866) 473-7768
www.nvpers.org

Nevada Division for Aging Services
(702) 486-3545 or (775) 687-4210
www.aging.state.nv.us

Governor's Office of Consumer Health Assistance (GOVCHA)
(702) 486-3587 or Toll-Free (888) 333-1597
www.govcha.state.nv.us

Public Employees' Benefits Program
(775) 684-7000 or Toll-Free (800) 326-5496
www.pebp.state.nv.us

As of December 2010

HOW TO FILE AN INQUIRY OR COMPLAINT

If you have an insurance question or problem, you should first contact your agent or company to get the matter resolved.

If you cannot get the matter resolved, contact the **Nevada Division of Insurance** for assistance. Inquiries or questions may be directed to the Consumer Services section at either of the Insurance Division offices.

In Las Vegas:
2501 East Sahara Avenue #302, Las Vegas
e-mail: cnsmsvlv@doi.state.nv.us
(702) 486-4009
or

In Carson City:
1818 E. College Pkwy, Suite 103, Carson City
e-mail: cscc@doi.state.nv.us
(775) 687-0700
Or, call **toll-free** anywhere in Nevada at
1-888-872-3234
www.doi.nv.gov

The Division of Insurance cannot recommend an insurance company or tell you which policy to buy. Our staff, however, can explain the insurance terminology in your policy to you. The Division of Insurance will also contact the company on your behalf in an attempt to help resolve problems you may be having.

POLICY CHECKLIST

You may find this checklist useful in assessing the benefits provided by a Medicare supplement policy or in comparing policies.

	Policy 1		Policy 2		Policy 3	
	Yes	No	Yes	No	Yes	No
DOES THE POLICY COVER:						
Medicare Part A hospital deductible?						
Medicare Part A hospital daily coinsurance?						
Hospital care beyond Medicare's 150-day limit?						
Skilled nursing facility daily coinsurance?						
Skilled nursing beyond Medicare's limits?						
Medicare Part B annual deductible?						
Medicare Part B coinsurance?						
Physician and supplier charges in excess of Medicare's approved amounts?						
OTHER POLICY CONSIDERATIONS:						
Can the company cancel or refuse to renew the policy?						
What are the policy limits for covered services?						
How much is the annual premium?						
How long before existing health problems are covered?						